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INTRODUCING

The JOURNAL *of* PASTORAL CARE

VOL. 1 AUGUST, 1947 NO. 1

EDITORIALS

THIS is the first issue of *The Journal of Pastoral Care.* Between its covers, the reader will discover a collection of professional presentations which, it is hoped, he will agree represents some of the better offerings for practitioners of the art and science of ministering to people.

The Institute of Pastoral Care will continue to publish this Journal, striving constantly to stimulate and to present original material in the field of pastoral care, and also re-presenting some few articles from time to time which have appeared elsewhere, but in magazines and publications perhaps unfamiliar to most members of the Institute.

The Institute of Pastoral Care offers the contents of each issue of the Journal enthusiastically and sincerely to the clergy, and to theological students. Other members of the healing professions will, it is believed, be interested in the Journal's contents, and perhaps will want to become members of the Institute. The growing interest which many doctors, nurses, psychiatrists, social workers, and clinical psychologists are taking in the form and content of religion, as well as in the religious orientation of their patients, is a matter pointing to more and more interprofessional research and practice to the benefit of all sorts and conditions of men.

The offering of each writer will be presented in his own name, and its publication in the Journal does not mean that the Institute of Pastoral Care officially endorses the author's thesis and conclusions. We welcome

heartily the contributions of men and women who, as a result of professional disciplines, experience, fairness of mind and goodness of heart, wish to share with the professional community to the benefit of all.

Readers' evaluations of our offerings in this issue, and in future issues, as well as expressions of criticism and of particular interest, will be most welcome. May we have yours?

The Washington Conference

A significant conference of clergy and psychiatrists was held this spring at the College of Preachers of the Washington Cathedral. It was sponsored by the Institute of Pastoral Care in cooperation with the Massachusetts General Hospital, the National Committee for Mental Hygiene, the Council for Clinical Training, and the Commission on Religion and Health of the Federal Council of Churches of Christ in America. Attendance was upon invitation only, and approximately forty persons were present.

Six relevant topics were chosen for exploration and discussion, including procedures of cooperation, marital counseling, functions and limits, and the relation of the counselor's philosophy of life to his therapeutic results. Each subject was introduced formally by a clergyman *and* a psychiatrist. A brief chapel service was held on the morning of the second day, at which Bishop Dun of Washington gave a most appropriate meditation.

An abbreviated summary is in the process of preparation and it is hoped that the Planning Committee will release this report for publication in the next issue of this Journal. Those who attended the meetings were in complete agreement that a second conference should be held.

The Pastoral Counseling Center

The Institute of Pastoral Care and The Cathedral Church of St. Paul have established in Boston a Pastoral Counseling Center with headquarters at 138 Tremont Street. This Center, which is inter-denominational in character, is the result of a pastoral counseling experiment initiated over a year ago by The Very Rev. Edwin J. van Etten, Dean of St. Paul's Cathedral. A high box pew in the rear of the Cathedral and directly opposite the Prayer Shrine was set aside for counseling. It was staffed by a group of volunteers. Here any person could turn for pastoral guidance. The results of this experiment indicated conclusively a genuine need for such a ministry.

The Pastoral Counseling Center, therefore, was established in January of this year under the direction of the Rev. Henry H. Wiesbauer. He has a Board of Advisors consisting of a psychiatrist, an internist, two psychologists, a social case worker, several parish ministers and interested lay persons. Besides providing pastoral therapy, Mr. Wiesbauer is also

offering supervised clinical experience in pastoral counseling under the auspices of the Institute. Individuals desiring further information should write directly to the Center.

New Associate Directors

The administration of the Institute has been strengthened by the election of two new Associate Directors, Rev. James H. Burns and Rev. Henry H. Wiesbauer.

Mr. Burns is Associate Protestant Chaplain at the Massachusetts General Hospital and a member of the Massachusetts Baptist Convention. He is a graduate of the University of Missouri and Andover Newton Theological School and has received a master's degree in sacred theology from Boston University. He has also done graduate study at Edinburgh and Oxford. Mr. Burns has had considerable clinical training, including a year as Clinical Fellow of the Institute, as well as institutional and parish experience.

Mr. Wiesbauer is Director of the Pastoral Counseling Center. He is graduate of Grove City College and the Philadelphia Divinity School, and has had nine months of clinical training. Following a few years in the parochial ministry, he became a canon at St. Paul's Cathedral, Buffalo, New York and Protestant Chaplain at the Buffalo General Hospital. He recently received a master's degree in social service from the University of Buffalo.

Godspeed and Welcome

After having launched the clinical training program at University Hospital, Ann Arbor, as well as establishing a Protestant chaplaincy, the Rev. Lawrence W. Pearson has returned to the parish ministry. Mr. Pearson submitted his resignation early this year in order to become rector of St. Andrew's Church, Aberdeen, Washington. We of the Institute are grateful for his pioneering in Michigan on our behalf, and we wish him Godspeed in his new ministry.

As Mr. Pearson's successor the Michigan Society for Pastoral Care has chosen the Rev. Malcolm B. Ballinger who began his new duties on May 1. Mr. Ballinger is a graduate of the University of Indiana and of Boston University where he was awarded both an M.A. in psychology and an S.T.B. cum laude. He has also had considerable clinical training. After six years of parish work in Indiana and Oregon, he entered the Army Chaplains Corp in 1943, serving in England, the Philippines, and Alaska. Following his discharge from military service early this year, he studied at Boston University and with the Institute of Pastoral Care.

We welcome Chaplain Ballinger as a new leader in both clinical training and the institutional ministry. He will represent the Institute as Director of Clinical Pastoral Training at the University Hospital.

The 1947 Summer School

A six-weeks course in clinical pastoral training has again been offered this year by the Institute, under the direction of Rev. James H. Burns, Associate Director. There are three sessions, two in Boston and one in Ann Arbor, Michigan. The Massachusetts General Hospital and the University Hospital continue to serve as training centers. For those students enrolled at Boston there is the additional opportunity of securing clinical experience at the Pastoral Counseling Center.

The registration fee has been increased from ten to fifteen dollars, and there is now an additional charge for certifying the training for academic credit. Students continue to assume the cost of their room and board. While the enrollment has been restricted, the quotas for all three sessions were raised for this year in order to provide for the increased interest in such training. A descriptive folder containing further details has been prepared and will be sent upon request.

Cooperation Between Clergy and Psychiatrists[1]

REV. ROLLIN J. FAIRBANKS
Institute of Pastoral Care

BEFORE considering procedures of cooperation between the clergy and psychiatrists, we should first examine the two professions — their similarities and their differences. A second preparatory step should be the exploration of those factors which indicate a need for cooperation. After these preliminaries have been dealt with, we can then devote our attention to the procedures themselves.

The Two Professions

Both the psychiatrist and the pastor are genuinely interested in people, particularly people who are in difficulty. Both professions have their "cults." The religious groups are admittedly more established since they have existed over a longer period of time. Their zeal and tenacity are no greater than that manifested in meetings of psychiatric and psychoanalytic organizations.

People usually come to both the minister and the psychiatrist on a voluntary basis. To be sure, there are those instances where they are sent by their families or even by courts (domestic, juvenile or otherwise). In such cases, however, both the pastor and the psychiatrist usually find it necessary to reconstruct the relationship on a less obligatory and more voluntary basis.

Furthermore, people come to us with the expectation of help of at least a semi-miraculous nature. The parishioner-patient usually indicates surprise, disappointment, or even annoyance when the clergyman or the psychiatrist indicates that his role is largely that of a catalytic agent and that the individual cannot expect to be a passive participant.

Both professions consider their interviews to be of a confidential nature. On the professional level this is not always strictly adhered to by the psychiatrist, while on the personal level it is sometimes violated by the minister. In neither case, however, has this become a very serious matter. In general, both groups have maintained high standards on this matter.

It is somewhat amusing but nevertheless corroborated by ample clinical evidence that both of our professions admittedly appeal to restless, maladjusted individuals, with the result that sometimes it would appear that the Christian ministry and psychiatry constitute sanctuaries for unhappy (but sometimes interesting) people.

[1] Paper read at Conference of Clergy and Psychiatrists, Washington, D. C.

What about the differences? The psychiatrist's relationship to his patient is always a professional one while the pastor's relationship to his parishioner frequently is a personal one. Payment of fees and securing appointments and meeting the therapist in a location devoted exclusively to diagnosis and treatment — all serve to strengthen the professional role of the psychiatrist. The absence of these factors for the minister render a professional relationship more difficult.

An even more basic difference is on the philosophical level. Our theories as to the origin of emotional difficulties or even mental disease are often contradictory. This, in turn, has influenced our attitudes towards our respective therapies — probably more so than has actually been necessary.

Of course, our training differs considerably. On the undergraduate level our education is often quite similar. In our graduate schools, however — the seminary and the medical college — we move in different directions. The would-be minister devotes three years to theory and historical material and only a minimum amount of time to clinical experience. Fortunately, this disproportionate curriculum is rapidly being corrected in several seminaries.

The embryonic psychiatrist, on the other hand, devotes four years to anatomy and physiology, thoroughly infiltrated with clinical experience, plus interneships providing training in the area in which he expects to practice — i.e., psychotherapy.

Need for Cooperation

Why is cooperation desirable or necessary? First of all, it has become disturbingly obvious that emotional and mental difficulties are increasing. The "load" already exceeds the skills and numbers of both professions. The social repercussions to personal predicaments are actually ominous.

A second factor is that our relationships with the parishioner-patient sometimes overlap. This is particularly true of situations involving marriage, bereavement, and guilt. Furthermore, there are times when our respective therapies need coordination.

A few years ago I received a request for a pastoral call from a patient in the psychiatric ward. Without making any preliminary inquiries, I went directly to her room where I found a rather stout, middle-aged woman who was seemingly in despair. I wanted to help her. She asked, "Is it possible to pray for something and get it?" Instead of trying to learn what it was that she was worried about, I naively replied in the affirmative, saying, "Yes, I believe that is sometimes possible." She thanked me and indicated that as far as she was concerned, the interview was over. Later that day the assistant resident chided me for confirming the patient's delusions. He explained that the woman's daughter had died in childbirth and that the mother assumed full responsibility for the tragedy. The latter had prayed and prayed that she might have a grandchild. God had answered this prayer but for a price. Obviously, coordina-

tion of our respective therapies would have resulted in less confusion for the patient.

Likewise there is considerable ignorance about each other which could be eliminated to a large degree through actual cooperation. Many clergymen have no idea whatsoever as to just what a psychiatrist does, what a psychiatric clinic is like, and how a mental hospital functions. So, too, (I suspect) there are perhaps a few psychiatrists who have no idea as to just what a pastor does, how he conducts a pastoral interview, or what goes on inside a church.

Occasionally we are blocked in our overtures toward each other because of emotional involvement. This psychiatrist once knew a minister, or that clergyman once went to a psychiatrist, and in each case the associations possibly are unpleasant. The fact remains, however, that closer cooperation will serve to strengthen the parishioner-patient's confidence in what is being done for him, and certainly this confidence is essential for his recovery.

Procedures of Cooperation

We have examined our respective professions and considered some of the reasons for cooperation between the two groups. Now let us turn to the procedures themselves.

One of the tragedies of the whole mental health problem is that emotional and mental disturbances usually develop to a serious degree before they are brought to the attention of the psychiatrist. Often, however, the early manifestations are apparent to the minister. One procedure, therefore, would be for the clergyman to be alert to such "danger signals" and for the psychiatrist to be prepared to confirm or dismiss the probability of incipient illness.

In some communities, of course, such psychiatric assistance may be delayed for a matter of weeks. What should the pastor do in the meantime? Some psychiatrists maintain that he should do nothing other than "catch" the patient, so to speak, and "sit on him" until the psychiatrist arrives. There are others, however, who believe that some "first-aid" may be in order.

Another possible procedure is the transfer of a relationship. This may be done through the simple medium of a written referral or by means of a three-way conference. Three years ago a psychiatrist who was completing his residency asked if I would be willing to see a patient of his occasionally, since he himself was leaving New England. The need was primarily one of supportive therapy.

A conference was arranged with the patient present, during which the resident explained to the patient my status in the hospital, his confidence in me, and my availability, and this interview certainly facilitated the transfer of the relationship. In most cases, however, it is the clergyman who refers to the psychiatrist. Rarely, however, does a psychiatrist "return" a parishioner-patient to the referring minister. In fact, it is an

interesting phenomenon that many hospitals and many physicians strive to shield their patients from the minister and religion. Their apprehension is not unlike that of the general practitioner who is fearful lest a psychiatrist tamper with one of his patients.

A third procedure is the matter of interpretation. Through cooperation both psychiatry and religion can be interpreted to the parishioner-patient. Likewise the patient may be interpreted to the pastor or to the psychiatrist. Frequently when a minister has had a pastoral interest in an individual receiving psychiatric care, he has called the psychiatrist, informed him of the dual relationship and asked how he could be of assistance. In most cases the patient has been interpreted to the clergyman in a very helpful way without necessarily violating the professional or confidential relationship.

There are times when the minister can interpret religion (or, more often, a denomination) to the psychiatrist. The clinical training of theological students and clergy, on the other hand, has helped to explain psychiatry to ministers. Occasionally the pastor's interpretation may include relating psychiatry or psychiatric insight to the problems of the general practitioner. The minister, of course, can often be useful in interpreting psychiatric care, particularly hospitalization, to the patient's family.

A fourth area for cooperation procedures deals with conflicts involving values. Religion in its higher forms is a philosophy of values and certainly Christianity is such a religion. These values might be classified as moral, aesthetic, and, in lieu of a better word, dedicatory.

> *Case 1:* A 27 year-old married woman, separated from her husband, and suffering from a reactive depression, told of an illegal abortion that occurred two years prior to her marriage. She seemed deeply disturbed and remorseful. Despite the therapist's neutrality and assurance, she felt a Commandment had been broken. She was encouraged to discuss this moral conflict with her pastor who, in turn, enabled her to review the incident from a Christian point of view and subsequently experience a sense of Divine forgiveness.

> *Case 2:* A 33-year-old married woman sought psychiatric assistance because of increasing marital friction. Although she repeatedly expressed the feeling that a divorce was indicated, she would hasten to comment, "But my church doesn't approve of divorce." Being unfamiliar with the laws of her particular denomination, the psychiatrist suggested that she might wish to discuss this aspect of her problem with her rector. This she did and in the course of two pastoral interviews, she found not only that she had been misinterpreting the law of her Church, but — as her therapist suspected — she had been disguising her own ambivalence. The third pastoral interview provided an opportunity to take inventory of her goals in marriage in the light of her religious tradition, while at the same time her psychiatric interviews enabled her to understand herself better.

Case 3: A 59-year-old unmarried teacher came to a pastoral counseling center because her prayers were not being answered. Each day she had asked God's help to rid her mind of "evil thoughts" (to use her phrase) about her sister who had died eight months before. Despite her devotional zeal, she continued to be plagued with unkind feelings towards the departed sister. Having some knowledge of the psychodynamics of bereavement, the pastoral counselor was able to review with the woman her relationship with her sister and the events surrounding her death. It was also possible to discuss comparatively the relevance of loyalty, conformity and honesty as part of God's will. It became apparent to the woman that her efforts to repress her hostility were unnecessary and futile, and that expressing this feeling verbally to the minister would not "cast her into outer darkness" but rather release her for useful service to God and those about her.

While this woman was not referred to the clergyman by a psychiatrist, such might well have been the case if she had first sought psychiatric assistance.

Occasionally one may encounter a conflict of aesthetic values in human relations. While this is not peculiarly a problem for the minister, since it does involve values and most psychiatrists maintain neutrality on such matters, it might well be referred to the pastor.

Case 4: A theological student and his wife sought the counsel of the minister who had married them. The original difficulty was incomplete sex relations. They had turned to a psychiatrist for assistance and he allegedly told the wife that she was hostile towards men and indicated that the husband might seek sexual satisfaction outside of marriage if necessary. The latter idea not only confused the husband but evoked a strong sense of repugnance. It clashed with an aesthetic feeling which he had for marriage and which, incidentally, undoubtedly contributed to his sexual restraint. The clergyman was able to renew with him the Christian concept of marriage, the place of beauty and physical satisfactions, and thus minimize to a certain degree the disturbing conflict, as well as orient the husband in regard to sex.

Although the frequency is very low, one occasionally encounters an individual who has identified himself with a cause or who feels a deep sense of consecration to a Divine Plan or the will of God. The psychotherapist would presumably be primarily concerned with its significance to the individual rather than judge the value of the cause. Because the concern is one of idealism, however, it constitutes a third area of values in which a sense of dedication is involved.

Case 5: A theological student was brought to an emergency ward for a psychiatric evaluation. In a conversation with one of his professors he had announced his decision to specialize in the ministry of music. While the goal itself was a worthy one, the methods by which he proposed to carry out this ministry were impractical, and somewhat bizarre. The psychiatric resident who

examined this patient was handicapped by his uncertainty about areas of specialization in the Christian ministry. The patient seemed to sense this and temporarily became unwilling to discuss his plan with him. The chaplain assured the patient of the resident's interest and suggested that it was an opportunity to inform one more person about the ministry. The patient then talked freely.

Case 6: A 34-year-old married man sought pastoral counsel, saying, "I want to serve God, not mammon." A marital problem had brought him first to a psychiatrist who interviewed the wife as well. After a third or fourth visit, the man felt that the therapist viewed his idealism (i.e., his desire to serve God) merely as psychological material and either was unable or unwilling to view it as other than that. Unfortunately this apparently caused the man to discontinue psychotherapy.

In unravelling or resolving moral conflicts the clergyman has the unique advantage of repre enting an institution which can provide moral approbation, particularly in situations of uncertainty such as a conflict between old and new attitudes. This has been most evident in the field of sex. Many Protestant groups support wholeheartedly sound, constructive, educational programs. Pre-marital interviews do not avoid that aspect of marriage. Literature is distributed by the pastor, and often the local physician is drafted to speak on he subject under church auspices.

What about therapy itself? Is there any place for cooperation there? Traditionally a single relationship is maintained — viz., that between the patient and the therapist. Others, such as nurses, orderlies or attendants, occupational therapists, and social workers are discouraged from participating (at least directly) in the therapy. All abreaction or discharge of feeling must be directed towards the therapist, and any willingness to listen upon the part of others serves only to retard treatment.

As the result of experiments with group therapy, there is now emerging a very new type of therapy involving multiple relationships. Instead of restricting the patient's opportunities for interaction, the therapist enlists the cooperation of all those persons operating within the patient's social orbit. The resulting material is then assembled by the therapist as a sort of mosaic. This facilitates both diagnosis and treatment.

If this second plan is followed, it is obvious that the clergyman will be welcomed and invited to contribute. The first or traditional policy, however, tends to exclude the pastor from any therapeutic program other than perhaps specifically sacramental approaches.

Of course, interpretation itself is a form of therapy and thus on this level the minister can certainly help. Likewise, the trained and experienced clergyman can also provide a certain amount of supportive therapy of a pastoral quality, just as the psychiatrist can lend supportive therapy for a parishioner. In either case the therapy may be temporary until insight and maturity are achieved. On the other hand, it may serve only in a palliative role because of a chronic situation.

With the rise of group therapy both psychiatrists and clergy have become aware of the therapeutic opportunities within parish organizations. Occupational therapy in a social sense can be carried out with benefit to both the individual and the group. The frustrations of a young mother who lives in an isolated part of town are bound to be magnified all out of proportion. Place her every Tuesday in a group of similarly "abused" wives and her difficulties assume a relative importance as she ceases to feel alone in her difficulties.

To what extent the minister can cooperate in the matter of insight therapy needs more clinical demonstration. On a few occasions it has worked very beneficially but the circumstances arose accidentally rather than by arrangement and agreement. Obviously such assistance by the minister would require special training and experience.

Preventive therapy, on the other hand, needs, deserves, and invites the cooperation of all professions. While it is never as dramatic as remedial therapy, nevertheless it is certainly more fruitful. Within the parish it can be carried out both through groups and through individuals. Releasing extreme tensions among adolescents, establishing healthy interpersonal relationships among children, recognizing the role of the "model" from whom an individual patterns his behavior — these are some of the opportunities that confront us.

The challenge, therefore, that lies before us as clergymen and psychiatrists is to lend these and other therapies to the total problem of management. This can be brought about by knowing each other better and studying our respective methods.

Summary

To summarize the foregoing discussion, the following eight conclusions are listed.

1. The welfare of the parishioner-patient necessitates closer cooperation.

2. Closer cooperation requires mutual and appreciative understanding of both similarities and differences.

3. Cooperation based on mutual respect and understanding between the clergyman and the psychiatrist can strengthen the patient's faith in his therapy, whether pastoral or psychiatric.

4. Recognizing early symptoms is a joint responsibility.

5. The transfer of relationships deserves further clinical consideration.

6. Interpretation offers an area for cooperation but requires understanding of the functions of both pastor and psychiatrist.

7. The recognition of the relevance of values is indicated.

8. In actual therapeutic procedures a program of joint-management is possible, particularly if the "multiple relations" type of therapy is followed.

PSYCHOLOGY AND APOLOGETICS[1]

DEAN WILBER G. KATZ
The Law School, University of Chicago

I want to discuss what I believe is a gap in the Christian scholarship and apologetics of our day. This gap or need is in the relating of modern psychology to the Christian doctrine concerning the nature of man and the redemptive action of God. This may, indeed, be the most promising — and the most pressing — task for Christian scholarship if the Church is to increase its influence in this twentieth century.

Unless I am mistaken, Christian apologetics must make increasing use of psychological insights in expounding the gospel and must also meet directly the attacks upon religion which have been made in terms of modern psychology. All I can do in this presentation is to outline some of the possibilities, but this may not be inappropriate if I can express my sense of the urgency of the task and perhaps interest individuals in working in this field.

If Christianity is to come to terms with contemporary psychology, we must have, in the first place, a comparative study of the teachings of psychology and religion as to the end or objective of man's development, and also as to the tendencies which obstruct his progress toward this end, and the means by which such progress is possible despite the obstructive tendencies.

Until very recently psychoanalysts and other psychiatrists have been reluctant to say much about the objective of their treatment or about the concept of a normal or healthy man. They have often seemed to speak in terms of a statistical average or of a test of mere ability to do one's work.

More recently, however, psychiatrists have felt secure enough in their status as empirical scientists to permit them to formulate their basic concepts. We find them discussing maturity and normality in terms of freedom, of capacity for love, for self-giving, for creativeness. The mature man, we read, is *angstfrei;* he is free from unconscious apprehensiveness, from the dread or anxiety which paralyzes action. He is a man who meets privations and frustrations without repression or rebellion, one who has resignation without apathy and without bitterness, one whose resignation is joyful acceptance of life. In the words of Dr. Ernest Jones, one of the English editors of Freud's works: " . . . the psychological problem of normality must ultimately reside in the capacity to endure — in the ability to hold wishes in suspension without either renouncing them or 'reacting' to them in defensive ways. Freedom and self-control are thus seen to be really the same thing . . . "

[1] An address given in Bond Chapel, University of Chicago.

This is the modern psychological concept of the mature man, a concept which Christian scholarship must compare with its conception of the man of faith, of trust in God, the man of creative love, the man who finds in the service of God his perfect freedom. One need not be qualified to work out the relations in order to be confident that these conceptions of religion may be made more intelligible to thoughtful people if use is made of the terms of contemporary psychology.

Such a comparison of the conceptions of psychology and of theology is important not only with respect to the goal of human development but also with respect to the basic tendencies which hamper such development. Psychiatrists tell us that these tendencies spring from the inability of infants and children to deal with their privations and frustrations in a mature fashion. The child reacts on the one hand by withdrawing in fear and becoming passive, developing inhibitions and repressing his frustrated desires. Or he reacts on the other hand with hostility and aggression which lead to further frustrations and repressions and to a sense of guilt. From these reactions spring the anxiety and the self-protective tendencies which are marks of psychological immaturity. Here the psychiatrist finds not only the roots of the neuroses of adult life but also the explanation of the large areas of immaturity revealed by the conduct of "normal" individuals.

These conceptions of the obstacles to the reaching of maturity require study in relation to the Christian doctrine concerning sin. In Christian theology the essence of sin is not the sinful acts but the absence of faith, the basic self-centeredness and self-protectiveness of man. Furthermore, Christianity has long had the insight that when man is without faith he always either asserts himself in aggressiveness and pride, or withdraws in sloth and fear. Christianity has known that pride and fear are twin aspects of sin. In the light of modern psychology, this insight suggests that at the deepest level these reactions are not contrasting but similar — that over-assertiveness in pride is the defensive reaction of a soul too fearful to accept its limitations; and that panic and retreat from life is the reaction of a soul which is too proud to accept frustration and failure.

Modern psychology has shown these tendencies to be deep seated and universal and the Freudian analysis of family tensions has portrayed dramatically the mechanism by which the psychological blocks to the achievement of maturity are transmitted from generation to generation. Perhaps Pascal would not have been so puzzled to account for the transmission of original sin if he had lived after the century of Darwin and Freud.

I have spoken of the goal of man's development and the tendencies which account for his failure to reach it. Comparison of the conceptions of psychiatry and religion is also promising in relation to the means by which man may overcome these tendencies. The passage from Dr. Jones which I have already quoted tells us that the problem of achieving normality or maturity is a problem of developing endurance, the capacity to hold wishes in suspension without repression or defensive reactions.

In other words, it is the capacity for suffering, for dealing consciously and realistically with pain, disappointment, anxiety, and failure.

But what do psychiatrists say as to how it is that suffering can lead to psychic advance? How can an individual be enabled to face his frustrations and failures without repression or defensive reactions? Psychoanalysts tell us that in the process of analysis this comes about through the patient's trust in the analyst, a trust which develops when the patient learns that the analyst does not condemn him and has respect and concern for him personally and confidence in his capacity to grow toward maturity. The relation of patient and analyst is not, of course, the only relation in which such growth can take place. Dr. Franz Alexander has recently cited as a model of brief psychotherapy the conversion of Jean Valjean due to the kindness of the bishop whose candlesticks he had stolen.

It is in the light of these insights concerning suffering that men of this generation may come to understand the Christian doctrine of the cross. They throw light also on the principles of pastoral care and on the ideal of the redemptive fellowship of the Church. The course of a psychoanalysis, furthermore, suggests the steps by which an initial venture of faith may enable a man to face his frustrations and failures and thereby increase progressively his faith and his capacity for endurance.

Traditional Christian philosophy has sometimes explained Christian freedom in terms of two freedoms, *libertas major*, and *libertas minor*. The greater freedom, the perfect freedom of submission to the will of God, is to be achieved, through the grace of God, only by the exercise of the lesser freedom, freedom of the will, in moral action. With the psychological insights which we have discussed we may be able to understand in some degree how it is that the exercise of freedom of choice can move us along the path to perfect freedom. It is because moral action always involves doubt and frustration, and it is the endurance of the resulting anxiety and suffering that gives to moral activity its liberating power.

But the task presented to Christian scholarship by modern psychology is not merely that of utilizing psychological insights to illumine religious doctrine concerning sin and salvation. Christian apologists must deal more adequately than I believe they have, with certain criticisms or attacks which have been based upon psychological knowledge. In the first place, Christian scholarship must deal frankly with the contention that religious belief may be the result of neurotic anxiety, the product of inner compulsions and not the free response of the soul to God. For thoughtful people of the present, this is one of the most serious stumbling blocks to faith. It not only keeps many from religious commitment of any kind but it also devitalizes in serious measure the faith of many church members. It is a critical point and requires serious consideration. It is not adequate to suggest, as two writers have done, that the Christian God can not be a product of wish-thinking because His demands are so severe and His judgment so fearful that Christian doctrine is the last thing one would create as a wish fantasy. This will not do since human fears as well

as wishes can motivate our beliefs and Christian doctrine does correspond dramatically to the deepest wishes and fears of man.

I think that Christian apologists must first concede to this criticism of religion a large measure of useful truth. We must all confess that what we call our faith is to a large extent not free response to God's grace but a self-centered insistence that our need be met. To this extent our worship is idolatrous since to this extent we have made our own god by projection of our wishes and fears. But to this admission the apologist may add that the argument does not purport to prove that all religious belief is analogous to neurosis. He may add also that modern psychology itself would lead one to expect that if a loving God exists, man could achieve a free response to Him only through the growing pains of successive stages of worship progressively less idolatrous. As Jung puts it, "Every psychic advance of man arises from a state of mental suffering, and it is spiritual stagnation, psychic sterility, which causes this state."

A second charge against religion which has drawn support from modern psychology is the charge that by emphasis upon sin and guilt religious teaching and practice has served primarily to reinforce the guilt feelings arising from the experiences of early childhood and to prevent the achievement of maturity and freedom. Nor can it be denied that the preaching of hell fire has often had this effect. But the remedy is not to have people close their eyes to their moral failures, their failure to mature. The task of the pastor is as delicate as that of the psychiatrist. Ultimately, full realization of one's moral and personal failures is necessary for spiritual advance, but the constructive facing of sin is possible only with the realization that one is loved in spite of his failures. The pastor's task in leading his flock to successive increments of self-knowledge and faith is exceedingly difficult, particularly since in his preaching he must deal with people in large groups.

This criticism of traditional religion has been leveled at Christianity in particular by Rabbi Liebman in his recent book "Peace of Mind." He speaks of Paul, Augustine, Calvin, and Luther as "obsessed by the notion of man's wickedness." He asserts that "the overall strategy employed by religion in the struggle against evil can be defined in one word: 'repression.' " He refers particularly to the passage in the Sermon on the Mount concerning the guilt of him who merely looks at a woman with lust.

Here is another task for Christian scholarship and teaching. Perhaps many have understood from this passage that Jesus was counselling the repression of desires by effort of will. But is not the thrust of the passage rather that the imperatives of the new law are beyond the powers of the human will? What is within our power — and what is enjoined upon us — is the opposite of repression: it is that we face our desires squarely. In the words of the collect for the third Sunday in Lent, the Christian does not repress his desires but beseeches God that he look upon them. If this prayer is not mere works but an act of will, it is the cry of one whose faith makes it possible for him to face his desires without repression.

In the article to which I have twice referred, Dr. Jones posed the question as to whether a normal mind can exist, whether freedom from anxiety can be achieved. He noted that psychoanalysis at present offers no prospect of removing every trace of the deepest layers of anxiety. His answer was a candid, "I do not know."

Christian theology has its answer to this question but the answer has not often been expressed in terms directly referable to modern psychology. The Christian answer, I suppose, is that freedom from anxiety can be achieved, but only by response to God in Christ. Such response is possible — because the Christian gospel is both the proclamation of God's love for sinners and the revelation of the standard and the possibility of perfect manhood. But have Christian writers and preachers made adequate presentation of the life of Jesus as the perfection of psychic maturity and freedom? They have long since been challenged to do so, for modern literature has more than once pictured Jesus as a neurotic reformer, desperately in need of love and driven to seek crucifixion by pressures of unconscious guilt.

Are we confident that such interpretations are at variance with the gospel record? Do we see there the chronicle of a Man who went through life with His defenses down, a Man who felt the temptation of short cuts to the accomplishment of His ministry and who showed in overcoming this temptation that no compulsive need for results crippled His freedom? Do we see a Man whose anger was objective and mature and whose love showed no trace of repressed sadism? Do we see one whose freedom permitted Him to respect to the end the freedom of others? Do we see in His agony in the garden, assurance not only that He shared our deepest dread but also that His sacrifice was freely offered and bears no marks of guilty craving for a martyr's crown? Do we see throughout His life a faith which is uniquely free, a response to God the Father which shows no hint of projection of neurotic hopes and fears?

The Christian answer to these questions is "yes," but Christianity will not meet the opportunity of this generation if the questions are ignored or the answer left to implication. The problems from which these questions spring may constitute the central task for the apologetics of our time.

PSYCHOTHERAPY AND RELIGION[1]

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AS a medical scientist who has spent a number of years in research dealing with psychopathology and with the therapeutic background of psychotherapy, three questions having to do with the relationship between medicine and religion have repeatedly presented themselves to me. These questions are: (1) What acts in psychotherapy? (2) Why is modern psychotherapy in the hands of physicians rather than in the hands of the clergy? (3) Why and how did psychotherapy escape from the field of religion, where it ordinarily found its place prior to the nineteenth century?

Before attempting answers to the questions, it should clarify the issues if I outline the background against which each question poses itself. I am not at present concerned with the wider meaning of these questions. Rather, I am interested in fitting these questions and their possible answers into the realm of knowledge of medical science. Let us consider the first question: What acts in psychotherapy?

Psychotherapy may be defined as the influencing of one mind by another with the intent of relieving mental pain, anguish, disorder, deviation, or illness, by means of the spoken (or written) word.

Psychopathology is frequently associated with physical illness, or it may occur without known physical pathology. For example, any individual suffering from some chronic disease like tuberculosis, or a dangerous condition like cancer, will be very apt to show abnormal behavior and to have mental experiences which are accompanied by uncontrollable anxiety. Another person may suffer from a similar anxiety and have no known physical pathology. We ordinarily do not consider that mental deviations associated with known physical pathology are truly psychopathological, since it is usually held that, if the physical condition were removed, the mental turmoil would disappear at the same time. This assumption is not wholly true. The physical disease itself may have produced some handicap, for example, stiffened joints in rheumatism. The disease may have interfered with the earning power or family responsibility of the individual for such a period of time that readjustment is difficult and reassumption of his planned place in the world impossible. The disease itself may have produced habits of thinking which are maladjustive and hence psychopathological.

Another setting which is frequently associated with psychopathology

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is that following unfortunate, unusual, painful circumstances which are beyond what seems to be the personal control of the sufferer. Such events as unrequited love, disappointment in one's children, marital discord, loss of financial security, death and accidents, and all of the other unfortunate happenings which bring marked unhappiness are included here. Generally we expect that the sufferer will react with some variety of melancholia or depression, and that after a sufficient period of time he will regain his mental equilibrium.

Generally one does not think of psychopathology in relation to the circumstances and occurrences which have just been named. Psychopathology is usually reserved for the description of the mental disorders and deviations which are without known cause, physical basis, or any other adequate associated explanations. The mental deviations accompanying the psychoses, neuroses, amentia, and other psychopathic states are the ones most usually called psychopathological. It might be pointed out that this peculiarity in thinking, namely, that psychopathology is only truly psychopathology when there is no physical basis, leads to many errors in the approach to the general problems involved. For example, there is no reason to believe that the anxiety state of the neurotic is psychologically any different from the anxiety experienced by the chronic tuberculous patient.

So far as the mental condition in any psychopathological state is concerned, no matter what its origin or lack of origin, it is usually held that there is nothing physical and little that is objective that can be done to relieve the condition. In our attempts to heal, cure, or alleviate psychopathology, we have recourse to words. These words may be conversation, advice, directed thought, attempts at mental habit training, and so on. Or they may be songs, poetry, or rituals. The words may be used with magical intent. The words may be used in a religious context in any sense of the meaning of the word religion. From these words the sufferer hopes to secure relief from his mental turmoil, comfort, reassurance, security, relief from loneliness, absolution from guilt, and promise for the future.

The sufferer has found, or has been told, that he will secure little or no relief through medicine, surgery, or other physical or objective means. He has found, or has been told, that it is "all in his mind." He has previously tried, or has been told of, many agencies, organizations, individuals, books, or methods which may provide some relief for his troubled mind. He knows of many individuals who have found relief through following any of the vast number of agencies or devices. On previous occasions his own troubles may have been relieved by any one of these diverse agencies. If his mental turmoil has continued long enough, one can be relatively certain that he has tried a number of agencies or methods and that he is willing to try almost any other agency or method, even though he is skeptical when he enters on any new procedure.

Out of all of these methods one can make the generalization that words heal, words cure, words bring relief. This brings us back to the

first question — how does communication through words act to bring relief, to cure, or to heal psychopathological states?

Our second question: Why is accredited and accepted modern psychotherapy a medical specialty rather than a clerical specialty? Modern medical psychotherapy begins with the work of Charcot in the 1880's, and its present development as a medical specialty can be attributed, for the most part, to the work and theories of Freud and the Freudian psychoanalysts. Although modern psychotherapy is largely psychoanalytically oriented, this condition might very well be termed an historical accident.

The history of the entrance of medicine into the problems of mental alienation is somewhat as follows: For centuries the insane had been taken care of in jails, almshouses, asylums, or other custodial institutions. The care of the insane was never regarded as a medical or clerical responsibility. The physician might be called upon to set a broken leg of a maniac, or the clergyman might be called in at the time of death. However, these were special incidents and were not regarded as part of the general responsibility of either professional group. The humanitarian movements leading to better care and treatment of the insane got under way about 1850, largely through the crusading efforts of Dorothea Dix. She brought to public attention the very deplorable status of the institutions which were at that time caring for the insane. This led to the founding of mental hospitals as we now know them. Her influence was followed by the crusading of Clifford Beers, who, during the first third of the present century, started mental hygiene as we now know the subject. This, essentially, meant attempts to prevent mental disease and disorder through better educational, social, and medical methods. The work of Miss Dix and Mr. Beers led to more adequate physical and medical care of the insane. Tuberculosis, pneumonia, and a variety of physical ailments were common among the insane. Because of these physical diseases, the physician came to play a greater and greater role in the care of these unfortunates. In order to bring about better physical medicine, the physicians found it necessary to convert the asylums into hospitals. Having made these custodial institutions into hospitals, and having provided in one fashion or another for the physical well-being of the patients, the physicians were left with the major problem of doing something about the psychopathology. Physical disorders and deviations were, to the physician, disease. Hence, by analogy, mental disorders and deviations were mental disease.

During the entire nineteenth century, the diagnostic classification of mental disorders was extremely varied. Each hospital superintendent or professor devised his own system on the basis of the immediate hospital needs or in the light of his own philosophy. During the 1890's Professor Emil Kraepelin devised a diagnostic classification of the major mental diseases. This system was so well conceived that it is still the one used in most European and American hospitals. Kraepelin based his classification on the principle of prediction. He personally studied many hundreds

of cases and reviewed thousands of case histories of mentally deranged individuals. From this he concluded that mental disorders could be divided into those caused by external conditions (which are or should be curable) and those caused by inherent factors (which may be alleviated, but which are essentially incurable). His viewpoint had in it an element of the fatalism of the natural scientist who observes phenomena as they occur but does not quarrel with their occurrence. Kraepelin assumed that mental diseases exist as separate entities and that, fundamentally, the cause of any mental disease is predetermined and predictable. For him the words curable or incurable were inaccurate since, without benefit of specific therapy, some patients will naturally recover and others will naturally fail to recover and so deteriorate. Thus, he pointed out that the course of the disease is predetermined in the same way that a chemical reaction is predetermined. The personal side of the patient's illness is incidental or accidental. This hypothesis is scientific, logical, and consistent, and it has dominated psychiatric thought for more than a generation. Kraepelin himself never started a "school" of psychiatry. He was a medical scientist in the best sense of the term. His approach was a true triumph in that it brought "insanity" into the field of medicine. As a result of this system of classification, better therapeutic efforts could be and were devised for the patients suffering from the so-called recoverable psychoses. It followed that more of those who were mentally ill recovered than had been previously true.

The history of the psychotherapy of the neuroses and psychosomatic complaints is relatively independent of the history of the care and treatment of the frankly insane. Until Charcot's investigation of hysteria and his application of the method of hypnosis in the treatment of this condition, little of a systematic nature had been attempted. Freud, following a year in Charcot's clinic, returned to Vienna where he made use of the methods he had learned in Paris. He soon found that it was possible to dispense with the hypnosis, and that better therapeutic results could be obtained by allowing the hysterical patient to talk freely concerning anything that came into his mind. This method, as it finally developed, consisted of allowing the patient to relax while permitting his thoughts to drift idly from one idea to the next. This process of free association was found to reveal much material which was previously unconscious. The material was verbalized and made available to both the therapist and the patient. In this procedure there were two objectives: one, to survey the unconscious material of the patient's mind through the application of the method of free association; the other, to show the influence which this unconscious material had had upon the patient's relationship with other human beings as well as upon his own mental life. It has been found empirically that this method produces an alleviation of the acute symptoms, and even brings about seemingly permanent cures in some patients suffering from hysteria, neurasthenia, and similar neurotic states. The best estimates indicate that 40 to 50 percent of hysterics are much improved or recover following psychoanalysis. The per-

centage is about the same for compulsive and traumatic neuroses. In other neurotic and psychotic states the rate of amelioration is from 10 to 30 per cent.[1]

To return to the traditional methods which were used by the clergy in caring for those of troubled mind, we can only note that they have continued with the methods of worship, prayer, confession and absolution, which for centuries past had been the standard procedure in approaching human ailments and unhappiness, whatever their nature or source.

It is pertinent at this point to digress to consider whether or not there has been change in the rate of mental deviation or disorder in the general population during the past two centuries. In all probability there is no increase nor decrease in the rate for the major psychoses — dementia praecox and manic-depressive insanity.[2] There is probably no change in the incidence of the alcoholic psychoses. There has been a decrease within the past twenty years in general paresis. There is a tremendous increase in the number of those suffering from the mental disorders of old age, which increase is associated for the most part with the increasing number of the aged. It is impossible to do more than guess whether or not there has been a change in the number of neurotic individuals in the population. These disorders are not reportable, are not institutionalized, and hence do not become a matter of public record. It seems a fair hypothesis that there has been an increase associated with the increased complication of modern civilized existence. One feature which is known to precipitate neurotic conditions is increased emotional stress or demands made upon an individual which are beyond his normal capability for response. Certainly there has been an increase in the number of individuals who have come to physicians with mental complaints. I do not know whether or not there has been a corresponding decrease in the number of individuals suffering similar complaints who have gone to the clergy.

I believe that background for the second question of why psychotherapy is a medical specialty rather than a clerical specialty is now clear. The medical profession met the problems in a systematic fashion as they occur in our everyday lives. The clergy were content to use those methods which had been found satisfactory during previous centuries without making a major attempt to meet new conditions.

This leads to the third question: Why and how did psychotherapy fall to such a low state in the field of religion? Religion has a variety of definitions. It may be regarded as an attitude which indicates belief in and reverence for a Divine power. It may be said to be a process whose general distinctive function may be viewed as consecration, reconciliation, or deliverance from evil. It may be defined as being concerned with the ultimate, or as an attempt to live in right relations with that which is

[1] C. Landis, "A Statistical Evaluation of Psychotherapeutic Methods." In L. E. Hinsie, *Concepts and Problems of Psychotherapy* (New York, 1937) pp. 155–69.

[2] C. Landis, and J. D. Page, *Moderm Society and Mental Disease* (New York, 1938).

of ultimate concern for one's existence. From the standpoint of psychotherapy, religion may be thought of as an attitude or process which provides ultimate meaning, particularly to one of troubled mind. Religion has utility in human existence in that it satisfies man's longings and desires for those things or conditions which are physically and mentally unattainable in this existence.

From a psychological point of view there are several ways in which religion plays a role in the mental life of the individual. It is an attempt to intellectualize a universal emotional experience. All attempts at making verbal an intellectual emotional experience are difficult, and none of them are too satisfactory. I do not believe that there is any other emotional experience in which such a consistent and determined effort has been made to make the process intellectually comprehensible and understandable as has been done for religious experience. A second method of use of religion is the postulation or declaration of an omniscient, omnipotent Divinity who is able to recompense, reward or punish, and so bring serenity to mankind, either in this existence or in an existence to come. In this sense religion is a human intellectual invention to supply the necessary balance for the individual experience of injustice and unhappiness. A third psychological use of religion occurs in its utilization by government. Religion is a successful device for stabilizing the social, economic, and cultural group so that many of the more obvious inequities inherent in the organization find compensation. It permits a social organization or a culture to operate where it might otherwise be inoperable.

Both from the view of utility and method, it seems that psychotherapy should be entitled to an honorable and important role in all religious concern. Religion is an attempt to intellectualize emotion; hence, religion should be able to deal with such problems as anxiety or guilt. Religion makes use of an all-powerful Deity who can reward or punish. Certainly, one who is troubled of mind needs reassurance, reward, and punishment. No group in a culture causes greater disruptive effects than the mental deviants. As a mechanism for social equilibration, religion might be expected to be primarily interested in psychotherapy. I am not aware of any body of evidence indicating that the clergy has approached the very real problems of present day psychopathology from an experimental or questioning point of view. There are a fair number of books dealing with one or another phase of the relation of psychoanalysis to religion, but these are chiefly speculative.

The background for these three questions should now be clear. It remains to consider certain probable or possible answers.

One of the best statements of what acts in psychotherapy is one which has been formulated by Prinzhorn as follows:

"What acts in psychotherapy? In the first place, the fullness of understanding of men, the leadership, the psychopathological experience, the wide view of life and the freedom from the private-ego proper to the psychotherapist; in the second place, the agitation, manifesting itself as

transference, of the patient tormented by loneliness, uncertainty and anxiety, the degree of the transference depending chiefly on the leader and on the special tone of the personal harmony; in the third place, the methodical thoroughness of the therapist, together with the diagnosis of the psychosomatic, and especially of the physically assailable, symptoms; in the fourth place, the transition to a way of life suitable for the patient (proceeding from practical life-technique to problems of culture and restraint, and so onward to religious ties). More deeply considered the effective agent in all this is; that the therapist, in virtue of the Eros paidagogos which inspires him, helps, as mediator, from the isolation that is full of fear, to wholeness of life, to new comradeship, to the world, perhaps to God. Without this form of the erotic, no psychotherapeutic curative action is possible. A psychotherapist cannot help, nor a patient recover, if this vibration is absent, or if it does not correspond to the special note of the situation." [3]

If this formulation is correct, then certainly psychotherapy is well within the proper scope of the clergyman. It is by no means limited to one of medical training. Prinzhorn, himself a physician, points out that in his opinion, the patient is more apt to follow the lead of a medical therapist, since the physician is free to question and to care for physical ailments. I regard this as a weak argument. The person above all who should have a full understanding of men, a sense of leadership, a wide view of life, and a freedom from self-consciousness is the priest. His concern is with the ultimate welfare of the individual. In the absence of a specific therapy he should be able to carry more authority to the suffering individual than anyone else. He already has an immense social prestige, so that his authority is psychologically more soundly based than that of any other individual, including the physician.

Recalling again the curative or ameliorative factors used in psychotherapy, we find that the following general procedures are available: (a) good advice, (b) fulfillment of wishes and settlement of conflicts, (c) enlightenment, (d) self-discipline and discipline of the will, (e) confession and absolution, (f) rebuilding toward a more desirable personality structure, and (g) transference (in the Freudian sense). Any or all of these factors should be at the easy command of the clergy. They certainly are not part of the regular training of the physician.

Prinzhorn has formulated specifically the relation of psychotherapy to religion as follows:

"The essential function of psychotherapy is the same as that of every religious community: Religio, binding back, giving the individual a refuge in something supra-personal, redeeming. Whether this is sought in a faith in God, in taking firm root in the psychosomatic reality, in a technique of life that is ascetic or epicurean, or sporting, or aesthetic, is, from the standpoint of psychotherapy, quite a secondary matter. As psychotherapy, its only concern is that the sufferer shall find a form of security for life, or self-realization, of unity with something greater than what his

[3] H. Prinzhorn, *Psychotherapy* (London, 1932), p. 332.

illness recognizes as himself — Nature, fellow-man, culture, community; principle of harmony with God, with universal life, to which all the foregoing are approaches. As regards method, then, all psychotherapeutic, like all religious leadership, must seek the sustaining mean between rational regulation and the devotion that redeems the lost." [4]

To my mind it is now clear that all that acts in psychotherapy is properly part and parcel of religion and should be adequately understood and dealt with by the clergy. The only exception to this occurs in somatic medicine, where treatment of the somatic condition is properly and rightfully the concern of the physician and surgeon.

If we return to the second question of why modern psychotherapy is medical rather than clerical, we may more clearly comprehend the issue if we ask the question of why the general public now takes its mental troubles to physicians rather than to the clergy. Anyone is free to draw up his own list of reasons for this. I submit the following which seemed important to me as a psychologist and without implying that they are in any sense an inclusive statement.

1. The physician offers specific individual help. He offers something tangible. His therapies are varied and seem, at least, to meet the particular problems of each individual rather than a generalized procedure which applies to everyone. He inquires at length into the specific difficulties, their apparent cause and their apparent effects. He frames his answers and his projected therapy in relation to modern medical science and cultural standards.

2. Generally speaking, most physicians now have enough training to offer adequate care for both mind and body, or, if one physician feels incompetent, he will refer a case to some specialist who has competency in dealing with the particular ailment. Medicine is past the place where it hands out a cure-all taken from a single bottle.

3. The patient hopes that the physician may find a somatic basis for his mental disability and, by curing the somatic complaint, relieve his mind and hence free him from the stigma of possible insanity. (Incidentally, the popular belief that insanity and sin are synonymous must be assumed as a responsibility of the theologian.)

4. The physician does not preach nor pray. He treats the ailing individual as a patient and, if necessary, hospitalizes him for more adequate therapy.

5. The medical men offer to the public the benefit of the newest discoveries in both somatic and psychological medicine. There is no general attitude that present day medicine is universally true and that its acceptance is necessary for cure or health.

6. Generally speaking, the medical profession offers a united front. They are not a group of warring sects, each preaching its own therapy which presumably is the only one which will cure the ailments of mankind. There is, of course, much disagreement back of the scenes but little of this ever comes to the attention of the general public.

4. Ibid., p. 329.

7. Physicians, educators, engineers, farmers, and manufacturers in our present day culture must meet the pragmatic test of delivering a product or a result which is thought good or desirable by the community. In the case of medicine it is absolutely true that there is less disease; that such disease which does exist is less severe; and that longevity, in our particular culture, has been greatly increased.

In view of reasons such as these, as well as others which might be listed, it is not surprising that the general public takes its mental troubles to the physician; and it is to the credit of the medical profession that, having been put in the position of responsibility for psychopathological conditions, they have taken over an entire field of activity foreign to them, and made it part and parcel of present day medicine.

The third question dealt with why religion allowed psychotherapy to escape it. Four possible explanations occur to me:

1. Religion deals with the ultimate. The physician is both willing and eager to deal with individual concerns and ailments. The physician is not concerned with the ultimate meaning of existence. He knows that he is forever condemned to a losing battle, and that every one of his patients must some day die. In spite of this he never gives up nor tells his patient, "Why should I worry about your headache. You're going to die eventually, anyway." It may be philosophically desirable to orient religious concern to the ultimate, but this fails to meet the very pressing, immediate need of the individual.

2. Protestant religion seems to have become largely a question of moral standards. In this conceptual frame-work the patient suffering from mental turmoil must have committed some sin, and in consequence, so long as he is a sinner, his mental turmoil is his just punishment. Contrast this to the medical attitude. For example, if a homosexual approaches a minister he is almost certain to be told he is a pervert and a sinner. When he goes to a medical psychotherapist there is no question of morals involved, but rather a question of what the psychological dynamics of his behavior and consequent attitudes may have on his general life adjustment.

3. Religion has to the common man become a fixed and absolute frame of reference. He has been encouraged to this belief. The common man considers that religion has failed to keep up with the changes in thought and culture which take place from generation to generation. All that the common man expects to hear from the clergy is a deploring of progress and a pleading for a return to the Rock of Ages. It is not unfair to say that a majority of the clergy regard psychopathology as a morbid, nasty subject, one largely comprised of sinfulness, and one from which the clergyman should keep as far away as possible. General paresis has long been said to be a just retribution for sin. The organized opposition to venereal prophylactic clinics comes from religious groups. Medical science has to a large extent conquered this disease in spite of religious opposition.

4. The clergy have been gullible. They have accepted and endorsed methods and proceedings reputedly of psychotherapeutic value which were actually fraudulent so far as public health and welfare were concerned. The crusades against vaccination, evolution, and prophylaxis for venereal disease are examples to the point.

My own personal belief is that psychotherapy should be a prime consideration in religion. It escaped because of a pre-occupation on the part of the minister with morals, philosophy, and short-cuts to Heaven. In brief, I would charge that the clergy have allowed themselves to be diverted from their proper place in our present culture, and that they are not adequately meeting a very real human problem which society legitimately expects them to handle.

No one of the answers to the three questions which I have posed is final, but I would maintain that psychotherapy (that which acts) is clearly part of the larger concept of religion. It has been taken over by the medical profession, and apparently the clergy have been glad to see it go. Whether this is socially or culturally desirable is a fourth question which I, a psychologist, now refer to the professors of philosophy.

METHODS OF PASTORAL COUNSELING

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THE urgent need for pastoral counseling is evident to those who can see. Americans are good at keeping up appearances of well-being. To the hasty glance it may appear that we are "healthy, wealthy and wise". We work in monumental buildings, dwell in charming homes, eat plenty of food, spend money generously, laugh hilariously and always say "Fine!" when asked how we are. Yet beneath the facades of grandeur and false fronts of optimism, "most men lead lives of quiet desperation" (as Thoreau observed). Within the mask (persona) of outward success the deeper struggles of personal life are won and lost. The personal crises, frustrations and failures may seem petty to the onlooker but they are decisive issues of human life. These dynamic motives of personal desire and defeat bear a harvest of interpersonal rivalry, social conflict, family discord and divorce, industrial strife, delinquency, war and exploitation, psychomatic illness, despair and suicide.

The pastor is in a strategic position to help persons who are under stress. He is usually well known and trusted in the community as a man who is unselfishly devoted to the welfare of others. He is interested in persons of all ages and conditions and available to them. He is welcome in most homes of the parish and with frequent association in church and community activities he may detect personality disturbances in early stages. He charges no fee for counseling and is free of the commercialism that infects most of the professions, where the high cost of services is a deterrent in seeking help.

Then why do people come so infrequently to the average pastor for counseling? They fear he will be shocked and shrink from the sordid impulses and sins of life. They have good reason from his pulpit utterances to expect he will condemn rather than understand their temptations. They know what he will say, they have heard the conventional moralistic answers time and again, but they somehow do not heal his distress. They have had authoritarian advice before from parents, teachers and preachers, and are not redeemed by the best advice in the world. They are apt to feel the pastor is irrelevant to their real needs, incompetent to understand or to provide effective therapy for their condition. He lacks the thorough training in psychology and methods of counseling which is required in psychotherapy.

The traditional methods of counseling used clumsily by the pastor (as well as parents, teachers and social workers of the old school) are next to

futile. They are ordering and forbidding, exhortation and persuasion, abstract logic and intellectual exposition, cheering up and reassurance, use of moral and religious authority, the prevalent you-ask-me-I'll-tell-you advice. What comes of these methods? Coercion produces resistance and revolt. Persuasion is also coercion in subtle form, seeking to put your ideas and choices over on me, implying my inability to think or decide wisely. Abstract logic may look impressive at a distance but it fails to apply to my concrete intricate situation; it leaves me cold. Cheering-up appeals sink the discouraged person more deeply into depression; reassurance represses the true feelings by neglecting them and demanding "higher" thoughts. Authoritarian advice either makes me submissive and dependent upon the adviser; or resisting and rejecting the advice to assert my independence.

No one has more clearly demonstrated the failure of directive counseling than Carl Rogers. With phonographic recordings of interviews he shows exactly how resistance develops when a client is directed to counselor chosen goals.[1] He shows the better results of following the counseling procedure of Otto Rank: (1) To focus on personal growth more than problems, (2) Attend to emotional attitudes more than intellectual information, (3) Explore the immediate situation more than the history, and (4) Realize that relationship is itself a growth experience.[2]

Rogers then elaborates his non-directive method of counseling in what may appear to many as revolutionary terms. (1) The counselor structures a relationship with the counselee that is permissive, i.e., free from judgmental attitudes of moral censure or condemnation. This will be no surprise to the physician, but the pastor is a defender of moral values. He may feel that he is betraying his moral duty if he is permissive. Yet Jesus said "Judge not" and "Neither do I condemn thee." Non-judgmental attitudes are essential to effective counseling. For as soon as we condemn, we separate the counselee as an outcast and the therapeutic relationship is broken. The pastor declares his moral convictions elsewhere, he is an eloquent witness to them by his own life, and he may well trust the counselee to feel such moral values without berating him about them.

(2) The counselor allows the counselee to tell his story in his own way, without directing by questions or controlling the conversation by the counselor's interests. This seems to many a pastor to cast him in too passive a role, where he merely listens or says "Hm-mh", while the counselee rambles afar and often repeats himself. The pastor has no time to lose and he wants to reach conclusions, he sees desirable goals and would like to hasten thereto. Yet haste often makes waste, especially when the counselee is repressing deeper feelings, or giving superficial assent to the pastor's goal. The progress is then not real growth for the

[1] C. R. Rogers, *Counseling and Psychotherapy*, Boston: Houghton Mifflin Co., 1942. The term *client* used by Rogers means "a dependent". We prefer the word counselee.

[2] Otto Rank, *Will Therapy; Truth and Reality*. Tr. by Jessie Taft. New York: Alfred A. Knopf, 1936; 1945.

counselee, but only standing on the side line while the pastor carries the ball across his goal with a glow of self-righteous victory.

(3) The counselor encourages the release of feelings no matter how unlovely they may be, for as long as they are repressed they continue to threaten peace of mind and distort true understanding. The pastor is apt to consider anxieties, hostilities and guilt feelings as morbid and try to direct attention to silver linings of "sweetness and light". Frequently the pastor may be guarding repressions of his own so defensively he cannot easily accept the negative feelings of the client. Yet the burden of repressed anxiety or hostility becomes unbearable unless wholesome release is found; and the wound of guilt is too deep to endure alone. When a pastor is willing to accept such feelings with understanding and offer the balm of divine forgiveness, the healing work proceeds.

(4) The counselor withholds advice, waiting for the counselee to discover his own insights and make his own decisions. This is democratic and Christian trust in the worth and ability of each person to see and choose what is best for him. But laud as we may democracy as an ideal, few of us practice it or believe it practical in every concrete situation. Pastors like parents and other executives are apt to feel the superiority which their leadership implies to see more truly and choose more wisely than the people they seek to lead. The typical love of authority is almost irresistible in the moral or religious field and as pastors we enjoy the exercise and inflation of such authority. To be non-directive is to be less important or influential in the lives of others we fear. Yet the folly of advice is equal to the deceitfulness of riches. The ease of giving advice tempts us to forget the difficulty of taking advice. And no matter how excellent the advice may be, it is no good unless it is accepted and acted upon. If you are a careful observer you will want to keep score and see what becomes of the advice you offer so hopefully. Even if followed the advice you give makes the counselee dependent on you when he should be learning to decide on his own to cope with new problems as they arise.

By this time you have guessed it is easier for me to agree with Rogers than with pastors who object so vociferously to his counseling methods. Every new crop of theological students in Pastoral Psychology joins the fray with argument and ridicule to annihilate these methods. Invariably I caution them that until they have learned to use the Rogers' method they are not ready to go beyond it. This is the best introduction to pastoral counseling I know. But that is not to take Rogers as the absolute authority or his sayings as the last word in counseling.

Non-directive method is a misnomer that confuses the exact procedure and gives rise to endless controversy. There is subtle guidance in every step of the Rogers' method. The counselor gives structure to interviews by defining the relationship as permissive. In restating the feelings the counselor selects for emphasis what he considers most significant. Without giving advice the counselor does affirm insights, clarify issues, state alternatives and encourage positive steps of action when chosen by the counselee. The counselor is not in a passive role but, as Rogers declares,

he must be alert every minute to see the deeper meanings, to sense the direction of the counselee's groping and to follow clues skillfully; thereby to guide the progress which the counselee is making. Without such selective and confirming activity by the counselor progress is unlikely to occur, and the hour is consumed in ramblings that do not reach significant conclusions.

The controversy rises from the dilemma of setting in opposition two extremes, both of which are unsatisfactory. The wholly directive method does violence to the counselee by coercing him to the goal chosen and put over on him by the counselor. Resistance or dependence are inevitable by this authoritarian method. At the other extreme the wholly non-directive method is passive, repetitive and disintegrating. It has the value of free expression of pent up feelings, the sense of sharing painful difficulties with a counselor who accepts and understands. But if it is actually non-directive the results are disappointing and distracting as the counselee hears only his own words reflected back to him. English teachers remind us that a good narrative has emphasis, coherence and progression. To gain these values in counseling calls for an active counselor who shares in the selection and sense of direction the two are travelling together to goals of progress. And of course this is exactly what Rogers presents in his samples of counseling. His methods work in practice, because they are neither entirely directive or non-directive.

I have proposed the term *responsive counseling*,[3] as a more accurate designation of what the pastoral counselor aims to do. This is a positive activity in contrast to the negative passivity implied by the term non-directive. To respond is to answer back. It is a sequel to a previous event, a reply to one who speaks first. By a permissive listening attitude the counselee is invited to speak freely and fully. The counselor is responsive to every mood, feeling or attitude expressed. By the strategy of the pause, he permits the counselee to take the lead in saying what he desires to express. But he does not pause after the counselee has spoken, for he has followed closely and is ready to respond by restating the feeling implied. In this response there is empathy, understanding and acceptance that draws the two into a relationship of intimate sharing. The counselee thus understood will more readily release deeper anxieties and reveal further the predicament that distresses him. This confession brings another response from the alert counselor to clarify the situation and select what is most significant for emphasis. In the sharing of these feelings and insights the counselor and counselee take alternate steps in progress toward solutions of problems, appropriate actions and interpersonal growth through mutual responsibility.

In responsive counseling responsibility for progress is mutual. A burden is better carried by two than one. If the counselor assumes too much responsibility he becomes over-directive. If the counselee is given the entire responsibility he is apt to make hasty choices, assume independence he does not have, make a show of strength he does not feel, or

[3] P. E. Johnson, "Clinical Psychology for the Pastor", *Journal of Clinical Psychology*, Vol. 1 (1945), 264–265.

become discouraged and dependent in the face of tasks for which alone he is not adequate. Democracy works by sharing responsibilities and reaching practical next steps by joint action. It is also the way Christianity works in bearing one another's burdens at the same time one carries his own.

The pastor will always need to be a good listener. He must listen well before he is ready to speak well. He must listen with his whole being, not just his ears, but his imagination, memory, empathy, understanding, faith and love. If he speaks from the depths of such a responsive comradeship there is new life in such a word. Richard C. Cabot and Russell L. Dicks [4] have pioneered in counseling methods for the pastor. They note that listening cannot always be passive, there is also a place for direction in the progress of listening. Too many questions or too long answers will prevent pastoral listening. If the counselor is responsive at every step he will share the leadership with the counselee as together they search for answers to needs, and enact the sufferings and joys of spiritual growth.

Is there a time and place for creative assertion?[5] The directive counselor speaks too often at too great length of his own interests. His assertions are inept and unapt to be creative. The non-directive counselor speaks too little, waits too often and hesitates to assert himself at all lest he interfere with the client's freedom. The responsive counselor listens first and replies briefly, but as the client reveals his true feelings and insights, there will be strategic opportunities for creative assertion in which both discover and declare together the way of life.

Responsive counseling is interpersonal appreciation. A responsive counselor is oriented first to the counselee in alert awareness of his feelings, his difficulties and his potentialities. He is oriented in the second place to the relationship in which the two are mutually responsible to the other to share the sufferings and discover the progress to be taken step by step together. In the third place "the two must face a Third"[6], as the orientation attains larger perspective. The order is not important, the orientation at all three points may be gained at once. But the honest pastor knows that true growth is not his creation or the counselee's but the work of the Creator God. Pastoral counseling may differ from other therapies at this point. A Freudian psychoanalyst may vest authority in himself as the healer. A Rogerian counselor may vest authority in the counselee as the one who solves his own problems. A pastoral counselor will vest authority in the Creative Spirit working in both through a relationship that is not a dualism of counselor and counselee, but a trinity of Creator, counselee and counselor.

To attain this triune orientation the pastor will use every means of grace at his disposal: prayer, scripture, sacraments, quietness, faith, resignation, friendship, listening, assertion, purpose and dedication into

[4] R. C. Cabot and R. L. Dicks, *The Art of Ministering to the Sick.* New York: The Macmillan Company, 1936.

[5] Ibid., pp. 262–267.

[6] Ibid., pp. 172–177.

religious service. None of them will be effective unless there is earnest response. There is no mechanical efficacy in ritual or repetition, as we learn to our sorrow when we put our trust in them. The creative event is a mutual response of God to man, man to man, and men to God. If God calls a pastor who responds; if the counselee seeks a councilor who responds; if together they seek the creative way of Divine life — the miracle of growth occurs. Counseling may be responsive at any level and to any degree. Pastoral counseling will not fulfill its opportunity short of the utmost response to the reality of interpersonal creation human and divine.

PASTORAL COUNSELING AS A CAREER

REV. SEWARD HILTNER
Department of Pastoral Services
Federal Council of Churches of Christ in America

IF one is as adequately trained as it is now possible to be in pastoral counseling and allied fields, what vocational opportunities of a special character are open to him? As I see it, the situation is about as follows:

First there is the pastorate itself. Here such knowledge can always be used to an advantage. Indeed, a number who have had special training, and have thought of a specialized vocation, have found that their new insight and skill so rejuvenated their parish ministry that they have decided to continue in it. A few large city churches are finding it possible to have, as one of several ministers on their full-time staff, one who is a specialist in counseling. There are not many of these as yet, but it may be expected to increase as the number of thoroughly qualified men increases. It is doubtful, however, whether it will ever be more than a few dozen. In most cases where a co-pastor specializes in counseling, he will have certain other duties as well.

The institutional chaplaincy is a very complex situation, and I have prepared for those interested a special memorandum on its vocational possibilities. It is entitled "Institutional Chaplaincy as a Career Service," and can be secured from the Federal Council of Churches, 297 Fourth Ave., New York 10.

Seminary teaching is another complex area for counseling skill. An article of mine entitled "Pastoral Theology in the Schools" in the book *Clinical Pastoral Training* gives the background. It now appears possible that a number of seminaries will want new men in this field in the near future; but in addition to counseling insight and skill they will demand (1) usually a doctor's degree (2) evidence that the men have a mastery of the whole pastoral field and not of counseling alone. Clinical pastoral training is a help, but is not enough, if one intends to go into seminary teaching in this field.

The teaching of clinical pastoral training is ordinarily done on the side while one carries out chaplaincy work or seminary teaching. Undoubtedly clinical pastoral training, then acting as assistant supervisor of such training, are indispensable for preparation. Some advanced academic work is increasingly recognized as valuable.

The field of research is not a career, but rather something done on the side to a teaching or parish job. Clinical pastoral training plus good

academic work and research toward an advanced degree would be the best preparation.

There are only a few administrative positions like my own in which, under church auspices, one's major energies are in promotion, education and study in pastoral counseling and related fields. There will, however, be more. Especially is the expansion likely to take place in some of the local councils of churches in larger cities, as well as in the headquarters of national denominations. Besides these posts, there are important administrative posts in the clinical pastoral training movement, in institutional chaplaincy, and in some other emerging movements. Any administrator at the present time must be a pioneer in this field; he can not rely solely on what has already been tried.

What about church counseling centers? The old "church clinic" idea seems to have died except for the few which have been operating for many years. The idea of a counseling center, however, under auspices of a local council of churches has now been tried successfully in two or three spots. While the administrative patterns demand further experimentation, it seems likely that the future will see development along this line.

The future may open a number of *new* opportunities along special lines for men with sound pastoral training. One thinks, for instance, of the clinics for alcoholics as a possibility. These may not open in droves; but a man with training, energy and a sound idea can have a good chance of success along some of these pioneering lines.

GRADUATE STUDY IN PASTORAL PSYCHOLOGY

The Institute of Pastoral Care offers summer and winter courses in clinical pastoral training. While the Institute does not award academic credits or degrees, it does certify work accomplished to theological schools, many of which give credit for Institute work. Ministers who are interested in graduate degrees in the pastoral field are referred by the Institute to the affiliated schools of theology and universities. A Committee on Graduate Study stands ready to answer inquiries and guide the progress of students who may desire to enroll for advanced degrees or studies beyond the Bachelor of Divinity course.

Andover Newton Theological School

Graduates of a college of recognized standing, who have earned the Bachelor Divinity degree with distinction in a seminary of recognized standing, may be admitted as candidates for the degree of Master of Sacred Theology (S.T.M.). Requirements include one year in residence at this school; a minimum of 10 hours a week in attendance at classes; a working knowledge of one language other than English; an honor standing in the 20 required hours for the year; a thesis on a subject acceptable to the Department and a defense of the thesis before the Examining Committee of the Faculty. Courses available to candidates for this degree in Pastoral Psychology are Clinical Theology, Clinical Psychology of Religion, The Psychology of Personality, Pastoral Counseling, Christian Forgiveness and Resolution of Guilt in Psychotherapy; and supervised reading and clinical training. Personal conference hours with the professor are provided for each graduate student. Credits for courses approved by the professor in charge which are taken in other graduate schools of Greater Boston are accepted. The dormitory accommodations are available for unmarried students only. For further information, write to Professor A. Philip Guiles, Andover Newton Theological School, Newton Center, Massachusetts.

Boston University

Boston University School of Theology offers the S.T.M. and the Th.D. degrees. The Graduate School of Boston University offers the A.M. and Ph.D. degrees in theological studies. For the Master's degrees one year of residence is required, with thesis or comprehensive examination, and other requirements as shown in the catalogues. For the Doctor's degrees 48 semester hours are required with dissertation, oral and written examinations, two languages, and academic work of distinction. The usual time required for a Doctor's degree is three years. Courses are offered in Pastoral Psychology, Psychology of Religion, Clinical Training, Clinical Psychology, Religion and Health, Vocational Counseling and Rehabilitation, History of Psychology, Interpersonal Psychology,

Psychology of Personality, Psychology of Religious Emotions, Psychology of Religious Leadership, etc. Clinical opportunities are available with supervision in nearby hospitals, clinics and prisons. Related courses may be taken in affiliated colleges and seminaries. For further information, write Professor Paul E. Johnson, Boston University School of Theology, 72 Mt. Vernon Street, Boston 8, Massachusetts.

Episcopal Theological School

CERTIFICATE COURSE

Students and ministers who have received a Bachelor of Divinity degree or its equivalent may be admitted to graduate courses in pastoral training. Courses are offered in The Ministry to Individuals, The Parish and the Community, Pastoral Counseling, Special Aspects of Pastoral Care, Pastoral Theology and Social Work, Case Seminar in Clinical Work. Clinical opportunities are provided in hospitals, social agencies, clinics and group work programs, penal institutions, community organization and survey. Such graduate courses lead to a certificate in pastoral care, requiring eight semester courses and 720 hours of field and clinical work in one academic year.

DEGREE COURSE

Graduate students may be admitted to Harvard University to study for the degrees of Master of Arts or Doctor of Philosophy, with arrangements for a field of concentration in pastoral care to be supervised jointly by the Department of Social Relations at Harvard and the Department of Pastoral Theology and Clinical Studies in the Episcopal Theological School. For further information, write Professor Joseph F. Fletcher, Episcopal Theological School, 99 Brattle Street, Cambridge, Massachusetts.

Harvard University

All graduate degrees in psychology, sociology and allied fields are obtained through the Graduate School of the University and not the Divinity School. Harvard has recently established a new Department of Social Relations which will concentrate primarily on studies in the field of social and clinical psychology, sociology, and social anthropology. All inquiries should be addressed to Professor Talcott Parsons, Chairman, Department of Social Relations, Harvard University, Cambridge 38, Massachusetts.

Housing and Finances

Questions of housing and financial arrangements may be taken up with the theological school or university in which the candidate decides to

enroll. Catalogues from each school will be sent on request to the Registrar of that school. Each member of the Committee on Graduate Study will be glad to answer questions directed to him. The names of members of the committee are given below, and addresses are given above in referring to respective theological schools. Communications to the Institute of Pastoral Care may be addressed to The Reverend Rollin J. Fairbanks, Executive Director, Massachusetts General Hospital, Boston 14, Massachusetts.

COMMITTEE ON GRADUATE STUDY

Paul E. Johnson, *Chairman*
A. Philip Guiles
Joseph F. Fletcher

BOOK REVIEWS

Problems in Religion and Life: Anton T. Boisen; Abingdon-Cokesbury, 1946. 159 pp. $1.50

To observe growth is always encouraging and interesting, and to find this growth articulated by a pioneer in the clinical training movement is another reason to support and encourage that movement to the benefit of Church and community. Dr. Boisen offers "detailed directions for intelligent study of individuals and groups." The material presented is provocative and stimulating, but it presupposes comprehensive orientation in the several social sciences and in theology if the "intelligent study" is to result.

In Chapter III, *The Individual And His Development*, Dr. Boisen says, in part, "The selection of cases (for study) should be limited to those which seem likely to repay intensive treatment. . . . For the 'down and out' little can be done." Is this possibly one of the last vestiges of the Church's mission being to the "good," of the "worthy poor", of the feeling that to be "down and out" is in itself predestination to rejection by the Church and society? Protestantism needs desperately to examine its attitudes in this whole area, and one sometimes sees reason for the criticism that Protestantism caters to the "middle" and "upper" classes only.

This book should enjoy wide reading by clergy, theological students, social workers, clinical psychologists, physicians, and the entire professional community. It is a real contribution to the literature of a field which is growing, and it is to be hoped this will prove one of the first volumes, in an increasing number, which will nurture and develop the comprehensive social level of research and study.

H. H. W.

Families in Trouble: Earl Lomon Koos; King's Crown Press, 1946. 134 pp. $2.25.

Under a grant from the Josiah Macy, Jr., Foundation, a study was made of 62 low-income families living in one city block. Most of the wage-earners were semi-skilled or domestic workers. On the whole, they were not aware of community resources such as Legal Aid and were possessed of a stiff pride which forbade them from accepting social agency counsel and made them feel stigmatized if they could not handle their problems alone.

Troubles were defined as situations outside the normal pattern of life which sharpened insecurity, blocked old patterns of behavior or called for new ones, and affected the intra-family relationships and the status of its members with resultant temporary or even permanent shift in leadership. A family is defined as "love-in-action, which includes interest, respect, the chance for interaction," and the major and tragic effect of trouble is its destruction of the foundations on which such interaction is based — security in each other.

Four criteria were used to test the adequacy of the family organization; consciousness and acceptance of the individual's role in the family and the complementary roles of all other members; willingness to accept some common definition of the good of the family in preference to the good of the individual member; finding of satisfaction within the family unit; and a sense of direction for the family as a whole and movement toward the goal.

The results of this study stress four important facts: (1) the *essential aloneness* of life (for this group even the spiritual director was too far away, too secure, to understand the problems); (2) the hunger of people to talk in the presence of someone *willing to listen;* (3) the importance of the *humanly significant* in human affairs, "the slow attrition of life trickling away into the sands," rather than the merely dramatic or colorful experience; and (4) the emphasis our culture places on the *ability to handle one's own difficulties.*

Mr. Koos underscores the need for broad human sympathy, highly personal relationships, and sharing, if a worker wishes to understand role devaluations, changes in dominance, and the full import of predicaments among his people.

I. M. G.

Modern Woman — The Lost Sex: Ferdinand Lundberg and Marynia F. Farnham; Harper, 1947. 496 pp.

Why is the modern woman unhappy? Because since the Industrial Revolution achievement and creative effort have been measured more and more in terms of the revenue they produce. Household duties and parenthood have become obligations rather than opportunities. The feminist movement, which sought to emancipate women and establish them as the absolute equal to man, "was misguided and led by neurotic women," and failed to provide any valid satisfactions.

The modern woman is dimly conscious of a betrayal. She was encouraged to be "like men" only to find that she has become an imitator at the cost of her own sexual identity. In her desire for success, she has unknowingly rejected those roles which distinguish her as a unique sex. It is inevitable that the resulting sense of frustration is being unconsciously bequeathed to the following generation.

Positive and constructive suggestions are made in the form of a social program. They will be left for the reader to discover. Needless to say this is a highly provocative and stimulating book which can aid the pastoral counselor in understanding the tensions and emotional conflicts confronting American women today.

R. J. F.

What Do You Advise? Fritz Kunkel, M.D., and Ruth Gardner; Ives Washburn 1946. 313 pp. $3.00.

The title of this book immediately raises a question in the mind of the reader, for it is generally believed that a good counselor does not give advice. This question is satisfactorily answered early in the book. The subtitle: *A Guide to the Art of Counseling*, is more descriptive of the contents of the book, which is di-

rected to teachers, social workers, vocational advisers, physicians, clergymen, parents, and those who would attempt self-analysis. Dr. Kunkel, exponent of the "We-psychology", and Ruth Gardner, co-author, discuss the dynamics of counseling as they are related to the client, the cure, and the counselor, and then illustrate and apply the principles of the "We-psychology" to counseling at various age levels and in different problem situations of men and women throughout life, such as the problems of masculinity, femininity, vocation, social responsibilities, marriage, parenthood, divorce, bereavement, illness, and the like.

The reader who has not read earlier books by Dr. Kunkel, expounding the basic principles of the "We-psychology," is likely to be somewhat confused at times, especially when mention is made of the egocentric types: the Star, Nero, Clinging Vine, and Turtle; or when the growth of the personality is described in terms of progress through the stages of the "We-experience:" the "Original-We", the "Breach-of-the-We", and the "Maturing-We." But all will be interested in the discussion of the problems of counseling, such as: the counseling relationship between the client and the counselor, the way to deal with resistance on the part of the client and with counter-transference on the part of the counselor, the techniques of handling the various steps in the cure, the educational, emotional, and vocational requirements of a counselor and of a psychotherapist, the part religion should play in psychotherapy and counseling, etc. The reader will hardly be in complete accord with all the ideas and conclusions presented on controversial issues, but in general will be stimulated to re-evaluate the principles involved.

Disciples of Carl Rogers' non-directive method of counseling will be interested in the commendation of the book: *Counseling and Psychotherapy*. Clergymen are likely to be pleased by the opinion that only the religious counselor with a real religious faith is able to help the client with anxiety. Students of the "We-psychology" and those who have profitably read earlier books by Dr. Kunkel, especially *How Character Develops* and *In Search of Maturity*, will find this book particularly rewarding. The principles of the art of counseling advocated by the author merit careful consideration by all who find themselves frequently consulted for advice. M. B. B.

NOTES AND COMMENTS

Alcoholism

One of the best pamphlets on this subject has been prepared by Herbert Yahraes under the excellent title, "Alcoholism Is a Sickness." Copies may be secured through the Institute or directly from Public Affairs Committee, 30 Rockefeller Plaza, New York 20. The price is ten cents.

Psychiatric Directory

A new and useful directory of psychiatric clinics in the United States is now available from the National Committee for Mental Hygiene, 1790 Broadway, New York 19. The price is fifty cents.

Emergency Baptism

The Institute has prepared an interesting and informative memorandum entitled "The Administration of Emergency Baptism." Physicians and nurses, as well as clergy, should find it useful. Single copies will be sent upon request.

Permission to reproduce in quantities is also available provided the Institute is granted the courtesy of being acknowledged as the source.

Communion for the Sick

A shortened form of the service of Holy Communion (as it appears in the Book of Common Prayer) has been printed for use with the sick and shut-ins. Single copies may be secured from the Institute without cost.

Understanding Children

The National Committee for Mental Hygiene (1790 Broadway, New York) publishes a quarterly which should be of interest and assistance to all pastors and church school teachers. It is entitled "Understanding the Child," and the subscription price is fifty cents.

Epilepsy

Probably the best pamphlet available on this subject is "The Epileptic: Who He Is — What He Can Be." The author, William G. Lenox, M.D., is a national authority. Copies may be secured from the American Epilepsy League, 50 State St., Boston 9, Mass. The Institute has a limited supply of reprints of Edith Stern's article "Good News About Epilepsy," a copy of which will be sent to any interested person without cost.

Mentally Retarded Children

Parents struggling with a feeble-minded child can be helped tremendously by realistic, intelligent, compassionate interpretation. This is now available in an eight-page pamphlet, "If Your Child Is Slow," published by the National Mental Health Foundation (Box 7574, Philadelphia 1) at a cost of eight cents each. There is also a helpful article, "Home Training of Mentally Deficient Children", by Grace D. Raynes. The Institute will supply this upon request.

Sex Instruction for Adolescents

"Growing Up in the World Today" provides sound and practical sex instruction for adolescents. It is published by the Massachusetts Society for Social Hygiene, 1146 Little Bldg., Boston, Mass. It is distributed free in Massachusetts and sells for twenty cents per copy elsewhere. The Society also publishes other worthwhile literature of real value to the parish minister.

Marriage

"Marriage and Sexual Harmony" by Butterfield is still one of the best booklets for pre-marital counseling. It is published by Emerson Books, Inc., (251 West 19th St. New York 11) at varying rates, depending upon the quantity ordered.